STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005022	A. BUILDING: _____ B. WING _____	C 08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOSPITAL INC	1606 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was for investigation of a State complaint. Complaint: #IN00131705 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005022 Survey Date: 08/26/2013 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Union Hospital Inc. is in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-1, Dietetic services, Hospital Licensure Rules. QA: claughlin 09/03/13	S 000		